

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4104

STATE FILE NUMBER 62-031376

VS 300
Rev. 4/59

1
2 3128
3
4 0
5 3
6
7 1
8 1
9 X
10
11 123
12 76-3
13

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

C. Kealhofer MEDICAL CERTIFICATION

1. PLACE OF DEATH- a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		Length of stay in lb 18 Years	c. CITY OR TOWN KANSAS CITY, MO. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 312 E. 9th Street. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JAMES D. WATERS			4. DATE OF DEATH Month Day Year AUGUST 6, 1962
5. SEX MALE	6. COLOR OR RACE N/A white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/28/89
9. AGE (last birthday) 72		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUCTIONEER		10b. KIND OF BUSINESS OR INDUSTRY AUCTIONING	11. BIRTHPLACE (City and state or country) MASSENA, Iowa
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JOSEPH V. WATERS	
13b. MOTHER'S MAIDEN NAME LILL BASOR		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 4/28/18 to 11/25/47		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT VA HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line to PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branch pneumonia DUE TO (b) Subdural hemorrhage + DUE TO (c) Brain contusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) was struck by a car	
20c. TIME OF INJURY Hour a.m. p.m. 7-21-62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	20f. CITY, TOWN, OR LOCATION Kansas City, Jackson
21. Attended the deceased from 7/22/62 to 8/6/62 and last saw him alive on 8/6/62 Death occurred at 11:10 PM 8/6/62 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature]		22b. ADDRESS 6627 Parkside Dr @ NW	22c. DATE SIGNED 8-8-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 10, 1962	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Fort Leavenworth Kansas
24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE REC'D. BY LOCAL REG. 8-8-62	26. REGISTRAR'S SIGNATURE [Signature]

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision:

Student _____

Signature of Student Embalmer

Signed

Carroll D. West

Licensed Embalmer No. 4096

P. O. Address 15. C. 2nd.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.